Project SEARCH INDEFINITE QUANTITY CONTRACT **SECTION A –REQUEST FOR TASK ORDER PROPOSAL (RFTOP)** ***HIV/AIDS EVALUATION,ASSESSMENT AND FORMATIVE RESEARCH***		
1	RFTOP Number	Uganda RFTOP 617-08-013
2	Date RFTOP Issued	**May 30, 2008**
3	Issuing Office	USAID/Uganda Acquisition & Assistance Office
4	Contracting Officer	
5	Proposals to be Submitted to	*Godfrey Kyagaba, A&A Specialist* *C.C to Sam Nagwere, Deputy A& A Team Leader* *Office: 256-41-306001* *Fax: 256-41-306661* *E-mail: gkyagaba@usaid.gov* *C.C: snagwere@usaid.gov*
6	**Proposals Due**	**June 30, 2008**
7	Payment Office	See Section B.4
8	Name of Firm	
9	IQC Task Order Number	
10	DUNS number	
11	Tax Identification Number	
12	Address of Firm	
13	RFTOP Point of Contact	Name Phone: Fax: Email:
14	Person Authorized to Sign RFTOP	
15	Signature	
16	Date	

SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

The United States Agency for International Development (USAID), USAID/Uganda, requires services of an implementing agency to conduct evaluations that will collect information and data as requested by the Mission and provide findings, analysis, and recommendations to inform current and future HIV/AIDS programming efforts in Uganda as detailed in Section C.

B.2 CONTRACT TYPE

This is a Cost Plus Fixed Fee (CPFF) type task order.

B.3 BUDGET

The Total Estimated Cost of this acquisition is $ (TBD). The Fixed Fee is $(TBD).

The contractor will not be paid any sum in excess of the ceiling price.

B.4 OTHER RFTOP INFORMATION

The final implementation plan for the task order that will result from this RFTOP will be incorporated at the time of award and shall be based on the proposal by the successful offeror.

END OF SECTION B

SECTION C – DESCRIPTION / SPECIFICATIONS/STATEMENT OF WORK

C.1.Purpose
USAID Uganda seeks the services of an implementing agency to conduct evaluations that will collect information and data as requested by the Mission and provide findings, analysis, and recommendations to inform current and future HIV/AIDS programming efforts in Uganda.

C.2.Objectives
1. To perform process, outcome, and impact evaluations of ongoing HIV/AIDS programs in Uganda
2. To conduct formative research and assessments to inform HIV/AIDS program design and policy
3. To synthesize data, findings and other sources of information in order to make strategy, policy, and programming recommendations to the USG and when requested, the Government of Uganda
4. Provide technical assistance to national and project level monitoring and evaluation systems

C.3 Specific Activities
This evaluation program will consist of six specific activities:

1. Formative assessment/situation analysis of orphans and other vulnerable children in Uganda
2. Formative evaluation of the Presidential (Ugandan) Initiative on AIDS Strategy for Communication to Youth (PIASCY)
3. Mid-Term Review Of The Expanding The Role Of Networks Of People Living With HIV/AIDS In Uganda
4. Mid-Term Review of the Health Social Marketing activity (AFFORD)
5. End of project evaluation of Hospice Uganda
6. Technical assistance to the Uganda AIDS Commission (UAC) for the operationalization of their Performance Monitoring and Management Plan (PMMP)

C.4. Assessment Methodology
A variety of complementary methodologies is expected to be employed in conducting each assessment. The team is expected to share their methodologies with USAID, relevant Government of Uganda line ministries/staff and other identified stakeholders before commencing field work. USAID will facilitate contact with relevant stakeholders.

C.5. Deliverables
The SOW includes the expected date of the final report for each individual activity. However, deliverable for each assessment/evaluation (or collectively) will include the following:

Deliverables	Week Due
1. An inception report to be reviewed by USAID, GOU and other relevant stakeholders as identified by USAID. The report will include:	TBD

Deliverables	Week Due
i) A detailed work plan showing a timeline for each assessment activity to be undertaken, including field work. ii) Methodology detailing data collecting tools, sampling/selection procedures for grantees and beneficiaries to be visited.	
2. Oral briefing with USAID, GOU and other relevant stakeholders to present methodology, data collection instruments and analysis plan.	TBD
3. Draft Report and oral presentations highlighting key findings, conclusions and recommendations. The oral debriefs will be made to (1) USAID and (2) USAID, GoU, and selected stakeholders. The draft report should be submitted in both hard copies (5) and one electronic copy and should conform to following specifications: ▪ Should not exceed 20 pages of text in the body of the report (excluding an Executive summary and annexes). ▪ Must conform to report structure contained in Attachment A. ▪ Should focus on questions posed by this SOW and include specific recommendations ▪ Must be processed using Microsoft Word 98 or higher and be in Times New Roman 12 point font.	TBD
4. Final assessment report incorporating feedback from USAID, GOU and other relevant stakeholders and should. ▪ be submitted in both hard copies (5) and one electronic copy. ▪ not exceed 20 pages of text in the body of the report (excluding an Executive summary and annexes). ▪ conform to report structure contained in Attachment A. ▪ focus on questions posed by this SOW and include specific recommendations ▪ be processed using Microsoft Word 98 or higher and be in Times New Roman 12 point font.	TBD
5. Data sets and 2 copies of all the instruments used in the evaluation. Cleaned labeled and ready to use electronic copies of datasets collected through fieldwork (preferable SPSS – PC format) and cleaned ready to use electronic copies of FGD responses if any.	
6. Dissemination to all relevant stakeholders.	TBD
7. Copies of final product printed and distributed.	TBD

The relevant scopes of work for the evaluations are included below.

ACTIVITY ONE

1. Formative Assessment of Orphans and Other Vulnerable Children in Uganda

Final Report: No later than one year from award of task order.

I. Technical Assistance Summary

The objective of the formative assessment is to 1) conduct an updated orphans and vulnerable children (OVC) situational analysis, and 2) identify the strategies, approaches and funding necessary to deliver comprehensive services to OVC in Uganda.

The last OVC situational analysis in Uganda was conducted in 2001 and was limited in both scope and geographical coverage. The study was mainly done by using orphans and their families in only eight districts; the resulting data was then extrapolated to all vulnerable children in the country. This analysis was used extensively in the development of the Ministry of Gender, Labor and Social Development's (MGLSD) National Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI). Since that time, the national OVC response has grown considerably both programmatically and financially. There is therefore a greater need to re-examine and better understand the situation of OVC in Uganda, including child and family access to comprehensive, evidence-based OVC services throughout the country, and the actual cost of delivering these services.

As a major OVC development partner in Uganda, the United States Government (USG) is supporting the Government of Uganda (GOU) through MGLSD to conduct a formative assessment to update the NSPPI and provide a more accurate baseline of the situation for OVC in the country. Data will be instrumental in facilitating country-wide planning and in improving future OVC program design and implementation. This assessment will also serve as a USG PEPFAR program area review to inform ongoing and future USG investments for OVC.

II. Background

Worldwide, the number of children under age 15 who have lost one or both parents to AIDS stands at more than 14 million, and estimates predict this number will surpass 25 million by 2010. The vast majority of these children – 11 million – live in Sub-Saharan Africa (Children on the Brink, 2002).

According to the 2006 Demographic and Health Survey (DHS), 56 percent of the Ugandan population's 27.4 million people are under 18 years of age. Single or double orphans make up 15 percent of these children, while eight percent are considered vulnerable (defined as children living in a household with an adult who was chronically ill or had died in the past 12 months preceding the survey). Approximately 46% of orphans are due to HIV/AIDS, and the rest are orphaned primarily due to conflict. Of those affected by HIV/AIDS, an estimated 100,000 children aged 0-14 are HIV positive. Of the four million children living in conflict, approximately 850,000 continue to live in Internally Displaced Persons camps (2007 UNICEF).

Like many other countries with a high HIV/AIDS burden, Uganda continues to struggle in its efforts to provide comprehensive, quality OVC services throughout the country. The National OVC Policy (NOP) and National Strategic Plan (NSPPI) defines OVC comprehensive core services as education and vocational training, psychosocial support, economic strengthening, health care, food and nutrition, basic care and support (shelter), child protection, legal support and mitigating the impact of conflict. Yet according to the 2006 DHS, an estimated nine out of ten OVC households were not receiving any type of external support, leaving the traditional social net of extended families picking up the majority of the OVC burden in the country. Of those households who did receive outside assistance, the most common services provided were education (6 percent) and medical care (4 percent). The National 2004-5 HIV/AIDS Sero-Behavorial Survey also found similar

results with only 23 percent receiving any kind of free, external support (education 14 percent, medical care 11 percent).

Uganda has made excellent progress in coordinating the response to the OVC situation in country. Through USG and UNICEF support to the Ministry of Gender, Labor and Social Development (MGLSD), Uganda has developed a National OVC Policy (NOP) with a costed five-year National Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI) to operationalize the NOP; a monitoring plan and national indicators that give guidance and direction to the numerous partners providing OVC services.

Current USG OVC Programming

The USG has played a key role in working with the Government of Uganda (GOU) to improve the availability and quality of OVC services; this support continues to increase through PEPFAR. The CORE Initiative for Youth, Orphans and Other Vulnerable Children is the prime OVC implementing partner within the USG portfolio. This five-year cooperative agreement provides critical support to the MGLSD in its efforts to lead, manage and coordinate the national response to OVC and HIV prevention among youth. Its purpose is to expand targeted HIV/AIDS services for youth and critical services for orphans and other vulnerable children by strengthening partnerships between the Government of Uganda (GOU) and civil society, faith based and community based organizations. This program is scheduled to end in September 2009.

Palliative/Pediatric AIDS Care – HIV positive children and those children living in homes with People Living with HIV/AIDS (PHAs) have been identified as key vulnerable children. Various USG partners are working in partnership to expand and strengthen access to pediatric HIV health care facilities for counseling and testing, and care and treatment services. These children and their caregivers are also being linked to other services including food, education, succession planning and legal support.

- The Mildmay Centre (TMC) is a faith-based organization operating under the aegis of the Uganda Ministry of Health since 1998 and managed by Mildmay International. TMC is recognized internationally as a centre of excellence for comprehensive HIV/AIDS care and training, particularly for children who constitute 36% of patients.

- Under the Civil Society Fund, grants will be given to expand the linkage between integrated pediatric clinical care and OVC community support services.

Uganda currently has six centrally PEPFAR funded partners implementing programs in all the major OVC program areas. These partners use many different models of services delivery in each of the OVC core service areas. The current FY08 total budget is about $4.1 million. These include:

- Africare in Ntungamo district
- AVSI in most of eastern, central, west and northern districts
- Christian AID with its partners focuses on Teso and Acholi districts
- Opportunity International with its partners UGAFODE focuses on Rakai, Lyantonde, Mbarara, Bushenyi, Ntungamo, and Ibanda and Habitat for Humanity Uganda in Kampala, Luwero, Mukono and Ibanda districts

- Plan USA (Plan Uganda, Save the Children USA and IRCU) covers Kamuli, Luwero, Tororo, Wakiso and Kampala districts
- Salvation Army in Bugisu, Soroti, Kampala and Masindi districts

The newly established Civil Society Fund for AIDS, TB and Malaria (CSF) is a partnership between development partners, civil society and GOU entities, including the Uganda AIDS Commission (UAC), MOH and MGLSD. Four donors, including USG (through USAID) are currently contributing resources to this fund for financial and grants management and monitoring and evaluation services. The CSF will initially fund grants focusing on national NGOs, OVC and prevention. Advanced talks are currently underway with the Ministry of Finance to use this mechanism to channel Global Fund resources to civil society.

Private Sector - Partnerships with national and multinational corporations to support and strengthen OVC services in the neediest communities are being developed. Efforts are being made to identify and initiate opportunities from the private sector to support long-term OVC services through community partnerships.

Conflict Areas of Northern Uganda - Since the beginning of 2007, there has been steady improvement in the security situation in Northern Uganda, evidenced by a declining number of rebel attacks, abductions and child night commuters. Thus the USG OVC focus in the North is shifting from one of emergency relief mode to development and reconstruction of sustainable systems.

Accomplishments

The MGLSD has also contracted eight Technical Service Organizations (TSOs). These TSOs serve as zonal coordinators with the goal of providing the vital link between the national level and Uganda's 80 districts. These eight zones cover an average of 10 districts. With MGLSD's mandate, the TSOs are responsible for disseminating national policies, principles, quality guidelines and protocols to districts and civil society implementing partners. TSOs are also tasked with strengthening the capacity of district Community Based Services Departments and local NGOs as well as mapping, planning, supervising, monitoring and evaluating comprehensive district level OVC services. In addition, the TSOs play a pivotal role in piloting the new OVC Management Information System. In efforts to address quality assurance, a key quality standards guiding tool for interpreting and applying national quality standards in each of the ten core program areas in the NOP was developed. This tool provides a structure and methodology to be used by OVC implementing partners to develop and apply relevant standards for comprehensive, integrated OVC services at all levels.

Gaps and Challenges

Despite the progress that has been made, there remains a serious gap in both the availability and the quality of core OVC services for children and families throughout the country. There are very few examples of successful evidence-based programs that are demand-driven, and that reach desired outcomes for children. It is challenging to draw upon and harmoniously integrate the technical knowledge, development paradigms and best practices of the many implementing agencies focusing on the different core program areas for OVC services (education and vocational training, psychosocial support, economic strengthening, health care, food and nutrition, basic care and support (shelter), child protection, legal support and mitigating the impact of conflict) into effective national-level implementation. There continues to be a lack of understanding as to the exact needs of

OVC and how these needs may change given circumstances, geographical location and age/sex of the child. Serious attention is urgently required to implement the quality standards guiding tool (mentioned above) at all levels and ensure that programs are making a measurable impact. The existing OVC guidelines, although evolving towards providing more comprehensive program standards, have yet to offer clear multisectoral direction. With additional funding anticipated to support OVC programming, notably through PEPFAR and Global fund, there is a pressing need to confront these challenges and opportunities to establish cost effective interventions that not only meet the needs of the OVC but are also distributed in an equitable manner both geographically and throughout the various sectors.

Definition of Vulnerable

Like most countries with high OVC populations, Uganda continues to struggle with finding an appropriate, country-specific term for vulnerable that is not limited in definition to only those children affected by the HIV/AIDS epidemic. A term that is detailed enough to provide guidance for making programmatic decisions, yet flexible enough to adapt to unique community-level needs such as the conflict situation in the North. The NSPPI defines vulnerable children as those who may be deprived of normal opportunities to lead healthy and happy lives regardless of the health of parents or guardians. These include children affected by armed conflict; abused or neglected; in conflict with the law; affected by HIV/AIDS and other diseases; in need of alternative family care; affected by disability; in 'hard to reach' areas; living under the worst forms of labor; and/or living on the streets. Yet anecdotal reports from community-level service providers indicate that communities, families and OVC themselves may often define vulnerable differently from the NSPPI definition. The 2004-5 HIV/AIDS Sero-Behavorial Survey defined a vulnerable child as under the age of 18, with one or both parents living in the same household who had been very sick for at least three months during the 12 months proceeding the survey, or a child living in a household in which an adult aged 15-59 had either been very ill or died in the preceding 12 months. The DHS used a similar definition in the 2006 survey. UNICEF indicates that children become most vulnerable in the 12 months preceding the death of a parent or guardian.

III. Objectives of the Assessment

Complete a formative assessment of the OVC response including full spectrum of the OVC core services: education and vocational training, psychosocial support, economic strengthening, health care, food and nutrition, basic care and support (shelter), child protection, legal support and mitigating the impact of conflict. Specifically:

A.

- Establish concrete, Uganda appropriate definitions of vulnerable, for purposes of programming, in agreement with MGLSD, UNICEF, line ministries and other relevant stakeholders.
- Using the agreed upon definition of vulnerable, establish current and projected future estimates of size and scope of vulnerable children situation (NB: done simultaneously with establishment of definition for vulnerable).
- Identify the strategies and limitations of coping mechanisms used by families and communities to address the OVC situation; independent of outside assistance.
- Building on assessments already conducted by USAID, UNICEF, CORE and CRD, evaluate the models of comprehensive service delivery currently in use, including community responses.

- Identify and provide recommendations for best practices and opportunities on how these can be utilized to scale-up the OVC program; Recommendations should be targeted to specific audiences such as the USG, GOU and OVC implementers.

B.

- Analyze USG current OVC contribution and focus and provide recommendations for future programming under the PEPFAR follow on.

C.

- Conduct costing analysis of comprehensive OVC services.

Points of contact / key informants:

- Key central government officials from the MGLSD, Uganda AIDS Commission, Ministry of Education and Sports, Ministry of Health, Ministry of Agriculture and Animal Industries and Fisheries, Ministry of Local Government, Ministry of Justice and Constitutional Affairs
- Local Government Officials at central and district level
- National, district and community level partners including NGOs/FBOs
- USAID representatives and members of the USG OVC PEPFAR Working Group
- The USG Monitoring and Evaluating the Emergency Plan Project (MEEPP)
- Development partners contributing to the CSF i.e. DFID, Ireland AID, Norway, SIDA
- Partners involved in disbursement and reporting on Global Funds
- The UN i.e. UNICEF, ILO, WFP and UNAIDS
- OVC and their families and the districts selected
- Others as determined appropriate

VII. Reference Material

- National OVC Policy and Implementation Plan
- USG implementing partner workplans and reports
- Recent completed assessments and reports, i.e. CORE midterm evaluation
- Social Protection: How important are the National Plans of Action for Orphans and Vulnerable Children?: Sabates-Wheeler, Pelham, October 2006.

VI. Team composition

The team should collectively cover the following fields or experience; CVs and recommendations can be made upon request.

- OVC service delivery in a multisectoral, decentralized environment
- HIV/AIDS with particular focus on the affected and infected children
- Public/Private partnerships, with a focus on government and civil society
- Capacity building of key governmental entities and service delivery organizations
- Organizational management
- Program monitoring and evaluation
- PEPFAR and global OVC priorities

ACTIVITY TWO

2. PIASCY Formative Evaluation

Final Report: No later than ten weeks after award of task order.

Background

In 2002 H.E the President of Uganda Yoweri Museveni, proposed a way to improve communication on HIV and AIDS among young people. The President's vision was for head teachers to address assemblies on HIV and AIDS every two weeks. Other teachers could then take the discussion into classrooms and clubs. The Uganda AIDS Commission (UAC) responded to the President's call and brought together line ministries, civil society organizations, the private sector and individuals working in HIV to forge a way forward, which led to the inception of the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY).

The PIASCY program is a national program designed to provide all school-going children and teachers with information on HIV/AIDS both to cope with the disease, for those infected and affected, and to prevent further infections. The broad strategies for the program are to: a) increase the capacity of a network of institutions (public and private) to continuously deliver learning resources and materials to schools, families and communities to increase behavioral change; b) increase the skills and knowledge of chief actors: teachers, parents, community leaders and pupils that culminate in the practice of behaviors that delay sex till marriage among pupils and students; and c) promote a stigma-free school environment in support of children infected and affected by HIV/AIDS.

The program is spearheaded by the Ministry of Education and Sports (MOES) and covers all primary schools in the country (approximately 15,000) and their communities. Targeting parents and communities reinforces activities delivered in the school. Parents are important actors within school programs and participate actively during school open days, parent-child dialogues, action-oriented meetings (AOMs) and music, dance and drama (MDD) activities. In-school activities include the use of school assemblies and clubs, talking environments, debates, talk shows to disseminate HIV/AIDS prevention messages to pupils and parents, and the integration of PIASCY messages into the school curriculum.

In 2003, USAID/Uganda, though its Basic Education Policy Support (BEPS) program supported the MOES to develop two PIASCY Handbooks—one targeting age appropriate messages for middle primary (P3 and P4) and one targeting upper primary (P5-P7). PIASCY was designed to provide all primary school-going children and teachers with information on HIV/AIDS both as a defensive as well as a coping mechanism against the pandemic and it employs a behavioral change curriculum in its entirety. BEPS spearheaded the orientation of teachers in the use of these manuals.

In FY 2005, the Uganda Program for Human and Holistic Development (UPHOLD) took over support to roll out and implement PIASCY, reaching more than 45,000 teachers in 15,000 public and private schools through training (3 teachers per school). UPHOLD has provided pre-service teacher training through Core Primary Teacher College (CPTC) Tutors and in-service teacher training through Coordinating Centre Tutors (CCTs) using a cascade training approach. The process began with a series of regional workshops for training of trainers (TOTs) who facilitated district teacher orientation meetings. Three teachers were drawn from every primary school, one of which was either the Head Teacher or Deputy Head Teacher of the school while the other two were usually the Senior Woman and Senior Man teachers. In FY 2005, UPHOLD consolidated its teacher training with an emphasis on establishing HIV/AIDS education as an integral part of primary school education.

From FY 2005 through FY 2007, UPHOLD's PIASCY Primary achievements included the following:

- Reached 5,830,335 children in primary schools with HIV/AIDS prevention messages;
- Trained 58,863 primary school teachers and education managers in PIASCY implementation across all districts countrywide;
- Distributed 113,616 copies of PIASCY materials countrywide including PIASCY Teacher's Handbooks, Guidance and Counseling Manuals and Charts, Community Involvement in Education (CIE) Toolkits, and Teacher's Guides for School Talking Environments;
- Disbursed School Incentive Grants amounting to a total of USh 742 million (US $440,000) to 1,078 model primary schools;
- Held PIASCY Performing Arts Festivals countrywide covering over 10,000 primary schools;
- Promoted 539 Safety Friends meetings at Coordinating Centre level;
- Held 732 primary school talk shows in model schools;
- Established Talking Environments in over 10,000 primary schools;
- Conducted 2,156 Action-Oriented Meetings focusing on HIV/AIDS prevention;
- Carried out monitoring and supervision activities with MOES staff in all districts reaching 80% of all primary schools.

In FY 2008, UPHOLD will complete implementation of its PIASCY activities in all primary schools in the country, targeting all primary school pupils in primary grades 3 to 7. UPHOLD will provide technical and financial support to Core Primary Teacher Colleges (CPTCs) to enable them to implement their activities. By September 2008, UPHOLD will have doubled the number of PIASCY Primary model schools from 1,078 to 2,156. These model schools are currently being nurtured through on-site supervision and school staff are mentoring nearby primary schools on PIASCY best practices. UPHOLD is supporting the CPTCs through model primary schools to disseminate prevention communication messages to primary school children through interactive activities that include rejuvenating primary school clubs, using PIASCY assemblies, implementing School Talking Environments, promoting child-centered participation in the Performing Arts Festivals, and encouraging peer-to-peer education. Aware of the critical role played by all key stakeholders, especially parents and caregivers in promoting responsible sexuality among their children, UPHOLD is also continuing to support school-community action oriented meetings (AOMs). These meeting address those risky situations that can lead to defilement and stigma. AOMs also address the need to care for families affected by HIV/AIDS as well as discuss individual roles and responsibilities.

By the end of FY 2008, UPHOLD will hand over its PIASCY activities to UNITY— Ugandan Initiative for TDMS and PIASCY that took over from BEPS. UNITY is a three year education project that began in November 2006. One of its major components is expansion of PIASCY implementation to both primary schools and post primary institutions. UNITY will deepen activities on HIV and Guidance & Counseling in primary schools. The UNITY Project will also introduce PIASCY to the post primary level of education by producing PIASCY manuals and Guidance & Counseling materials, and disseminating them nationally but with a focus on the Northern Region. Information from this formative

evaluation (e.g., lessons learned and best practices) will inform implementation of UNITY's PIASCY activities.

Objective

The objective of this formative evaluation is to evaluate the effectiveness of PIASCY interventions to date in order to provide GOU/MOES, USAID/Uganda and other stakeholders with lessons and recommendations for adjusting program strategies and/or activities for continued implementation.

Key Questions

In general, the formative evaluation should provide insight into the effectiveness of the implementation of PIASCY under BEPS and UPHOLD and the factors which should be taken into consideration for the continued successful implementation of PIASCY under UNITY. USAID/Uganda expects that the formative evaluation will provide answers to the following questions:

1. Is PIASCY achieving its planned goals and objectives (e.g., increased capacity to deliver learning resources and materials, increased skills and knowledge of chief actors, and promotion of stigma-free school environments)?
2. What are the strengths and limitations of the design, organizational structure and rollout of PIASCY?
3. What are the lessons learned and best practices for continued rollout of the program?
4. What are the unintended consequences from the development and implementation of PIASCY?
5. What are the sustainability issues that will need to be addressed in handing over the program?

Relevant documents and key contacts

Relevant documents -

- all BEPS and UPHOLD PIASCY program documents and reports
- Ministry of Education and Sports (MOES) PIASCY Handbooks for Teachers
- National Strategic Plan on HIV/AIDS
- MOES Workplace Policy and Strategy on HIV/AIDS.

Key informant interviews with BEPS and UPHOLD PIASCY activity participants, including but not limited to the following:

- BEPS and UPHOLD staff directly involved in designing and delivering PIASCY activities
- MOES PIASCY Coordinating Unit staff
- District Education Officers
- Core Primary Teacher College Principal and/or Deputy Principal outreach staff
- Primary Teacher College Tutors
- Coordinating Centre Tutors

- Primary School Head Teachers and/or Deputy Head Teachers, Senior Women, Senior Men and any other primary school teachers who participated in PIASCY training activities
- primary school pupils
- primary school pupils' parents/guardians and community leaders
- Uganda AIDS Commission
- Civil Society partners (i.e., FBOs).

Expertise Required

- The evaluation team should include:
- A team leader with five to seven years experience in conducting educational evaluations in developing countries;
- Project evaluation experience in sub-Saharan Africa in general and Uganda in particular
- Expertise in formative evaluation, quantitative and qualitative research methods

- Demonstrated experience with HIV/AIDS prevention among youth
- Excellent English language oral and written communication skills are mandatory.

3. Mid-Term Review Of The Program For Expanding The Role Of Networks Of People Living With HIV/Aids In Uganda

Final report: No later than three months after award of task order.

BACKGROUND

It is estimated that over 1 million Ugandans are living with HIV, at a prevalence rate of 6.4 per cent. Currently just over 100,000 People Living with HIV (PHA) are accessing Anti-Retroviral Therapy (ART), which represents just over 40% access to ART. Over 200,000 PHA are under care and support. Over 70 per cent of those infected do not know their HIV status and only 23 per cent of the population has received HIV Counseling and Testing (HCT).

Although there has been a rapid scale up in the availability of HIV/AIDS care and treatment services through the USG and MOH collaboration, the services are only benefiting a number of Ugandans while many more remain unable to access HIV and AIDS care and treatment services. There have been increasing concerns about ensuring the high quality of HIV/AIDS treatment services and ensuring adherence to ART and Tuberculosis regimens in order to limit the development of resistant TB and HIV strains.

In recognition that services rendered at facility-based setting are not always accessible to the patient in need, and that not all community and home based settings have the adequate resources or clinical support needed to provide quality care, USG and the Alliance have developed a network model that incorporates referrals systems in HIV/ AIDS services delivery, reduces stigma and brings services closer to the community. The International HIV/AIDS Alliance received funding in July 2006 from USAID to implement a 3 year project on "**Expanding the Role of Networks of People Living with HIV/AIDS in Uganda"**. The

goal of the program is to strengthen the capacity of PHA networks and groups at sub-district and community level and improve access to HIV prevention, care, support and treatment.

The project uses the Network model which ensures that a patient is able to access a complete package of care throughout the HIV stages of disease progression. The model recognizes the fact that PHA and PHA groups and networks are best positioned to facilitate and manage the referral systems and linkages between home and community based care and health facility based care thereby providing a comprehensive continuum of care for their members. People openly living with HIV are engaged and deployed as Network Support Agents (NSAs) to support delivery of HIV services in health facilities and within communities. PHAs are a key resource in improving linkages between communities, health facilities and community based services.

PHA groups and networks are mobilized and access grants through the project to provide services to their members and facilitate referrals and linkages between facility based and home based care and treatment. The program also aims to build the capacity of PHA groups and networks to act as community service delivery points for HIV services and grants are provided to enable groups to carry out home based care, adherence counseling, HIV prevention activities, patient tracking and to promote linkages between the home and community based care and health facilities.

Prior to the amendments in 2007, the program intended to cover 14 districts in Uganda. During its first year of implementation, the project was implemented in seven districts, three in the central region: Luweero, Mukono, Kalangala; four in the Eastern region: Jinja, Iganga, Mbale and Katakwi. The project successfully rolled out the community engagement and network model with support from stakeholders at all levels. The program has spearheaded a remarkable increase in clients accessing prevention, care and treatment services in health facilities through mobilizing communities, HIV/AIDS education awareness and referral linkages to services. In the first year of implementation the program has trained and placed 83 Network Support agents (NSAs) in 43 health facilities in 7 districts to support delivery of HIV and AIDS services, conduct effective partnerships and referral linkages of communities to services. The program has achieved results exceeding the first year targets. Through support to 63 PHA groups, the program has provided HIV/AIDS education and awareness prevention to over 50,000 people, anti-retroviral therapy (ART) literacy and education services to 27,114, adherence counseling and support to 24,492 PHAs and HIV/AIDS counseling and follow-up counseling to 25,403 clients and 6,358 referrals for health facility and community-based services. It has also been observed that in health facilities and communities where the NSAs are engaged, there is tremendous improvement in ART access and adherence.

The project established, strengthened and maintained partnerships with the Ministry of Health (MoH) and organizations providing HIV treatment and care, care for orphans and vulnerable children (OVC) and wrap around services and a referral system was developed through deployment of the NSAs. A performance monitoring and evaluation plan was developed and a systematic monitoring and reporting system was set up to gather data on how the project contributes to Uganda National Strategic Framework for HIV/AIDS Activities and the USAID Mission in Uganda's Performance Monitoring and Evaluation Plan.

The Network Model

The Network model was developed in collaboration with USAID in recognition of the weaknesses in the existing linkages between HIV services and traditionally non-HIV related services. The Networks model supports constrained health facility and community based delivery systems whilst putting affected populations at the core of the response to HIV and AIDS producing results rapidly and at scale. The program supports linkages between HIV services with non-HIV related clinical services and communities, enhances support for adherence through multiple avenues and involvement of PHAs, and establish best practices for linking facility-based care to community-based care for HIV and AIDS. This program facilitates referral systems that ensure a patient is able to access a complete package of care throughout the HIV stages of disease progression. The program continually identifies, implement, document and will share the best practices. The program also provides support to USG partners such as NUMAT in incorporating these approaches into the HIV/AIDS continuum of care across facility-based and community-based care settings.

In order to scale up the model USAID increased funding in September 2007 to enable the program increase coverage to cover 28 districts and the total estimated amount of the agreement was increased by $4,700,000 from $3,000,000 to $7,700,000. The 21 additional districts to be covered include; seven districts in Western region: Kabarole, Kasese, Kyenjojo, Kibale, Hoima, Bulisa and Masindi; three districts in Central region: Nakaseke, Nakasongola and Kayunga; five districts in Central-eastern region: Bugiri, Kamuli, Namutumba, Busia and Mayuge; four districts in Eastern region: Manafwa, Sironko, Palissa and Butaleja; two districts in South-western: Kanungu and Kabale. The program specifically focuses on the following areas:

1. Mobilize and strengthen the capacity of PHA groups and networks at community and sub-district level for effective coordination and improved access to HIV/AIDS services for HIV/AIDS in 28 focus districts.

2. Facilitate access for PHAs and their families to comprehensive package of services that improve their quality of life.

3. Increase access of PHAs and their families to HIV/AIDS prevention, care and treatment services and, other support services such as orphan support, family planning, food and nutrition and economic strengthening, through increased involvement of PHA groups at sub-district and community levels as both participants in delivering services and as beneficiaries of comprehensive continuum of services through a network model.

4. Support innovative approaches by PHA groups at sub-district and community levels to enhance the operationalization of the network model through the management of a small grants program.

2. PURPOSE

The Cooperative Agreement for the PHA Networks program between USAID/Uganda and International HIV/AIDS Alliance is a 3 year agreement that runs between 10th July 2006 and 9th July 2009. As a major partner, USAID and the USG PEPFAR Country Team are interested to assess and learn from the successes and challenges of the project design, strategies and performance, to strengthen and improve project planning, strategic focus

and operational delivery during the next 18 months of implementation. This assessment will also support and inform ongoing USG investments in scaling up HIV/AIDS prevention, care and treatment and expanding the role of PHAs and PHA networks in prevention, care and treatment services in Uganda.

The mid-term evaluation will assess whether start-up activities went well and determine whether there is early evidence pointing to program objectives being reached and sustained. The evaluation will extract lessons for the benefit of on-going and future programs and provide insight into the role of PHAs as alternative sources of human-resources for health.

3. KEY QUESTIONS

Design

- How is the Alliance Network project contributing to the achievement of GoU and USG goals regarding increased access to HIV prevention, comprehensive continuum of care, treatment and support and is the project able to demonstrate this?

- Is the USG support through the Networks program a recommended approach to continue supporting in order to achieve GoU and USG goals regarding increased access to, and utilization of HIV prevention, care, treatment and support services?

- Does the project design and structure adequately support and facilitate achievement of the desired results?

Performance

- Is the Networks project on track to achieving its overall objectives and results as outlined in the results framework, work plan and reports? Is the project yielding any unintended positive/negative results?

- Are the systems and mechanisms for documenting lessons and good practice in terms of the Network model effective, what examples are there of the use of learning to improve the project? Is the project monitoring and evaluation system functioning as designed; is it delivering the necessary information to support documentation of lessons learnt?

- Is the process of providing grants to PHA groups well designed, administered and evaluated? What recommendations can the team make on the granting system? How are grants contributing to achieving the project's expected results within the model?

- Is the emphasis placed at the community, sub-county, and district levels appropriate? Has the placement of NSAs in health facilities made some difference in increasing PHA access and utilization of HIV prevention, care and treatment? How effective are NSAs as an alternative source of human resources for health?

- Are NSAs adequately supported with regard to ongoing training, support and supervision?

Management, coordination and staffing

- How has the requirement for significant scale up within the same project timeframe affected the management and operational delivery of the project? Is the project staffing structure appropriate to support program development and scale up?

- How are partnerships developed and maintained with US Government, GoU, civil society and other stakeholders? How does the project work and maintain partnerships with others to address key issues it's not able to address and to ensure access to wrap around services, such as malaria, nutrition, reproductive health and family planning?

- What are the risks associated with rapid scale up of this approach? How can these be mitigated against?

5. INFORMATION SOURCES/REFERENCES

The team will review all related documentation, including but not limited to the following:-

a) Program description (original and revised)
b) Global draft guidelines on task shifting
c) Annual work plans, PMP and reports(annual and quarterly)
d) Baseline assessments
e) Data capture by PAH groups and NSAs and reporting procedures
f) USAID PEPFAR strategy with respect to network model
g) MOUs between the program and MOH and other implementing programs,

6. EVALUATION TEAM COMPOSITION

The team should consist of a team leader and of members with the following specific expertise and experience.

- Ability to utilize flexible judgment based technique using mixed method approaches to synthesize findings to reach evaluation conclusions.
- Experience with HIV/AIDS services including: ART, palliative care, patient monitoring, PMTCT, HIV/AIDS Counseling and testing (HCT), TB/HIV, lab, nutrition, prevention and other community support services; and solid understanding of integrated service delivery model(s) in a decentralized system;
- Understanding of the national context including: policies, strategies, guidelines, priorities, challenges, gaps, achievements and best practices in HIV/AIDS services
- Experience in working with volunteers and PHA networks
- Substantial expertise in program management and evaluation.
- Familiarity with the USG's Emergency Plan for AIDS Relief and participatory evaluation methods are highly desirable.

ACTIVITY FOUR

4. Midterm Evaluation Scope of Work
- Afford Health Marketing Initiative In Uganda.

Introduction:

AFFORD is a 5 year USAID funded initiative whose objectives are to achieve the sustainable marketing of products and services that prevent the transmission of HIV/AIDS, malaria, and diarrhea diseases, help couples plan their families and help people living with HIV/AIDS (PLWHAs) enjoy a healthier and improved quality of life. AFFORD provides the technical assistance and capacity building necessary to make these achievements sustainable in Uganda through local institution(s).

The Health Marketing Initiative uses innovative marketing and communication to achieve broad public health impact across Uganda. It enhances the commercial distribution of products and services that have direct public health impact for all Ugandans, while an integrated communication strategy increases demand and empowers individuals, families and communities to take an active role in maintaining their own health

AFFORD Vision is Consistent/correct use of health products/services key to growing sustainable markets; satisfied users lead to increased consumer demand, new operators entering marketplace, greater competition and strengthened, more responsive market institutions. The result is Ugandan families, communities are empowered to protect and improve their health, markets for health products, and services are vibrant and expanding; and increased access and affordability of products and services.

Specifically, AFFORD focuses on three key results:

1) Increasing accessibility and affordability of HIV/AIDS, Reproductive Health, Child Health, and Malaria prevention and treatment products and services through innovative (marketing) approaches.
2) Enhancing knowledge and self efficacy towards, and correct use of, HIV/RH/CS/Malaria products and services to encourage healthy lifestyles; and
3) Strengthening/establishing indigenous organization and distribution systems for sustainable delivery of health marketing functions.

Partners on AFFORD include UHMG, PULSE Communication Ltd., Aclaim Africa Ltd., Communication for Development Foundation Uganda (CDFU), Malaria Consortium East and Southern Africa, The Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs, and Constella Futures.

AFFORD's Strategic Approach
1. Adopt *consumer driven approach* to health marketing to increase market size
2. *Establish partnerships* between UHMG and Ugandan organizations for Family Planning and health product procurement, packaging, distribution and promotion in order to improve efficiency, share costs, and promote sustainability.
3. *Extend/strengthen existing distribution and service delivery systems* to increase consumer access & reduce market risks
4. *Increase/strengthen demand for services/products*, and create common wellness and healthy lifestyle platform

5. *Provide targeted subsidies on products* to vulnerable populations, increase linkages with local dist, retailers, NGOs
6. *Establish UHMG* - continue implementing sustainable health marketing after AFFORD has ended

Background:
Health status

Family planning Uganda is a predominantly rural nation whose population is growing at a rate of 3.4% per year, having maintained one of the world's highest total fertility rates (TFR) at an average of 6.7 children per woman(UDHS, 2006). The median age of sexual debut is under 17 years of age, and half of the women have had their first birth by age of 19. (UDHS, 2006). The contraceptive prevalence rate (CPR) is low at 24%. In contrast, women's ideal family size in Uganda is 5 children and 41% of the married women want no more children or are sterilized, 31% want to wait 2 or more years for the next birth and 16% want to have a child within two years 13% of the births in the five years preceding the UDHS, 2006, were not wanted. Inadequate knowledge of Family Planning and access to reproductive health services and family planning (FP) products not only contributes to this very high TFR and low CPR, but to unacceptable levels of maternal and neonatal morbidity and mortality as well. (UDHS, 2006).

Child health Diarrheal disease, malaria and other preventable diseases that threaten child survival are also prevalent throughout Uganda, resulting in unacceptably high under -5 mortality rates of about 137 per 1,000 live births and an Infant Mortality rate of 75 per 1,000 live births (UDHS,2006). An important underlying cause of infant and child morbidity and mortality is inadequate nutrition, evidenced by the fact that stunting affects nearly 40% of children in Uganda. Primary prevention and early treatment, as well as hygiene promotion, safe water, and micronutrient supplementation are all critical elements of a comprehensive strategy to improve survival rates for infants and under-5s, and to help surviving children stay healthy and productive in school and into the world of work. Different partners and strategies are required to reach established targets in these areas, and the role of the private sector is increasingly important.

Malaria continues to be the leading cause of morbidity and mortality in Uganda, where it is endemic in 95% of the country. Up to 40% of outpatients attended in health facilities and up to 20% of inpatient, deaths are due to malaria. Each year, an estimated 70,000 to 110,000 children in Uganda die from malaria (Malaria Control Program, 2005). The Health Sector Strategic Plan II (HSSP II) especially targets pregnant women and children under five for prevention, vector control and case management. Key activities in the strategy include broader distribution and use of ITNs, home based management of fever, intermittent preventive treatment for pregnant women, and sound Information, Education and Communication/Behavior Change Communication (IEC/BCC) interventions for malaria prevention and control.

HIV/AIDS Uganda has achieved considerable success in responding to the HIV/AIDS epidemic since the virus was first identified in the early 1980s. It is well accepted that Uganda's decline in HIV prevalence is unique in Africa. A major contributor to the decline in HIV prevalence is the prevention approach Uganda adopted and popularly known as the ABC of prevention. This approach recognizes that prevention rests on changing risky behaviors, particularly engaging in early sex, having many sexual partners, and having sex without condoms. The ABC approach reverses these and promotes delaying sexual debut

and abstinence (A); being faithful to one negative partner (B); and using condoms consistently and correctly if having sex with a partner whose status is not known (C). The national response to the HIV/AIDS epidemic has also been characterized by its multisectoral nature, political commitment and leadership at the very highest levels, and openness about HIV.

Uganda experienced a steady decline in HIV prevalence from a peak of 18% in 1992 to the current figure of 6.4%, (UHSBS, 2005). Declines in prevalence have however stagnated over the past four years. Population based surveys and longitudinal data indicate that new infections continue to occur within the population, especially among married and established couples. Results from the Uganda Sero Behaviorsal Survey (UHSBS) indicate that women are more likely to be infected with the virus than men and that for both sexes HIV infection levels are highest in the 30-40 age groups and remain lowest in the 15-19 age groups. Many people infected with HIV do not know their status and consequently remain a risk factor to transmitting HIV to their partners. Slightly over 800,000 million PLWHAs and over 2 million children are either orphaned, live with and care for ill parents or face other vulnerable situations because of HIV/AIDS. Strategies to combat the spread of HIV/AIDS, provide care and treatment for the infected and affected, are not keeping pace with the evolution of the epidemic. Therefore, dramatic innovations are needed in the range and quality of prevention, care and treatment interventions in order to reach larger numbers of people.

2) Public – private partnerships

Uganda's Ministry of Health (MOH) has long acknowledged the contribution of the private sector to national health development, as articulated in the HSSP II. The Public/Private partnerships in health are seen as a key element contributing to a health care delivery system that is "effective, equitable, and responsive" (HSSP II, p. 10). In addition, the HSSP II considers health marketing approaches as a mechanism for scaling up maternal and child health services (ibid, p.32)

USAID Uganda is implementing a number of initiatives that support the MOH's objective of strengthening the public/private partnerships. Chief among these initiatives is health marketing, support to private providers, and workplace health services. USAID Uganda has supported the marketing of health products since 1991, whereby health products, such as contraceptives and mosquito nets for instance, are made available through private sector providers and commercial outlets at a subsidized price. Social marketing of health products and services helps to create service delivery channels that can alleviate the load of the public sector, thus freeing it to better provide for the needy.

The Ministry of Health/Reproductive Health Division has frequently acknowledged the contribution of the marketed contraceptives and related promotion activities in increasing contraceptive use through the private sector. Sales of other products at subsidized prices, particularly insecticide treated nets (ITNs) and condoms have been steadily on the increase.

USAID-supported marketing activities have evolved over time to include a broader range of products, providers, delivery channels, and marketing approaches. USAID Uganda's current health marketing program includes a variety of FP, malaria, HIV/AIDS, STI products and services available through pharmacies, drug shops, private clinics, the workplace, faith-

based organizations, and other non-governmental organizations. In designing the current health marketing initiative, USAID Uganda has placed high value on sustainability, and the creation/development of a viable local health marketing entity that will gradually replace all the functions that AFFORD has been carrying out.

B. PURPOSE:

The AFFORD Health Marketing Initiative is a 5 year agreement between USAID/Uganda and Johns Hopkins University that runs between September 21st 2005 and September 20th 2010, with the first three years being the base period. Depending on the availability of funds and the achievement of the required results during the base period, USAID will authorize funding for an additional two years for a total of 5 years. This midterm evaluation will therefore focus on AFFORD's performance and effectiveness during the 3-year base period. As such, it will provide a fundamental basis for determining continued USAID funding over the next two years.

AFFORD should be assessed against achievement of the 3 objectives described in its agreement with USAID Uganda. Objective 3, "to strengthen / establish an indigenous organization and distribution systems for the sustainable and self-sufficient delivery of key health marketing functions" is **central** to this mid-term evaluation. The determination of a 2-year continuation agreement hinges on evidence that this objective is well underway and can be achieved within the continuation phase.

The mid-term evaluation will also confirm that AFFORD is on target to achieving its other programmatic objectives. The evaluation will highlight strategies that are promising and should be continued, as well as those that have not delivered expected results and should likely be refined or discontinued. The evaluation extract lessons for the benefit of on-going and future programs and provide insight into the role of the commercial sector in increasing the availability of quality health marketing initiatives. This assessment will also support and inform ongoing USG investments in enhancing marketing strategies for health. USAID is particularly interested in assessing the sustainability of this initiative along various dimensions: technical, financial, and organizational.

C. KEY EVALUATION QUESTIONS

Design

The AFFORD Program is rooted in a number of the frameworks and policy directions developed by the Government of Uganda (GOU) and the USG, and must contribute to the goals expressed in each. USAID Uganda's current health marketing program includes a variety of FP, malaria, HIV/AIDS, STI products and services. Typically, health and social marketing efforts target urban populations, and increasingly those living in mid and small towns. The mid term evaluation should take into account the following overall questions:

- the effectiveness of marketing tools and strategies developed by AFFORD for each of the products they carry, including but not limited to segmentation , audience profiles, distribution channels, product pricing and promotion

- the relative attention AFFORD accords each health (HIV, FP, Malaria, child health, others) with respect to level of effort, budget, and revenue
- the extent to which the project design and structure support and facilitate, or hinder, achievement of the desired results
- the extent to which the project design and structure accommodate uncertainty and emerging issues
- the extent to which AFFORD builds partnerships to attain objectives
- the role of research/evaluation in AFFORD's assessment of its own performance

Achievements

The mid term evaluation should as well focus on the progress and challenges to date in attaining the specific objectives outlined in the AFFORD agreement.

Objective One: Increase the accessibility and affordability of HIV/RH/CS/Malaria products and services for communities and families in Uganda, through innovative private sector approaches.

- What strategies has AFFORD implemented under this objective? How do they determine whether these strategies are effective in increasing access and affordability? Are there strategies that were tried with a negative result, conversely were there proven strategies that yielded negative results, and how were these addressed.
- Assess the way(s) in which AFFORD defines and measures reach of its products and services, as a way to determine increased accessibility and affordability (e.g. is reach defined at the end user, the local shop, the distributor level)
- Does the product distribution structure developed by AFFORD maximize efficiencies, and provide for delivery of products in an expanded array of entry and delivery points, does it effectively provide access to the products by specific population groups
- What are some of the innovations brought by AFFORD to health marketing in Uganda? With what effect at this mid-term point?
- What are some of the key challenges and successes to date under this objective, for each of the products and services in AFFORD's portfolio. How did AFFORD address each? With what result?

Objective Two: Enhance knowledge and correct use of HIV/RH/CS/Malaria products and services to encourage and sustain healthy behaviors and lifestyles within communities and families.

- What strategies has AFFORD implemented under this objective? Assess their appropriateness to enhance knowledge and correct use of intended services and products.

- Do these strategies strike an effective balance between promoting product sales and fostering increased and correct use of HIV/FP/Malaria prevention, care, and treatment products and services
- Are there promising approaches that AFFORD has introduced to reach this objective? What makes them promising?
- Assess the reach of AFFORD's effort under this objective, and how reach is defined: is it generic or is it defined by the product (e.g. knowledge of all condoms or knowledge of Protector)
- What are some of the key challenges and successes to date under this objective
- How do AFFORD's implementation modalities maximize or otherwise limit the attainment of objectives one (marketing emphasis) and two (communication emphasis)

Objective Three: Strengthen/establish indigenous organization(s) and distribution systems for the sustainable and self-sufficient delivery of key health marketing functions, including management, distribution and promotion.

- Is UHMG established as a Ugandan-led and locally registered organization that will have the capability to effectively manage and implement the AFFORD program,
- Has AFFORD taken required steps to ensure UHMG has a governance structure, Ugandan leadership, ability to receive and manage USAID grant funds directly, and a financing plan that moves the organization towards greater financial independence.
- Is there a credible and realistic implementation plan to achieve the AFFORD program and UHMG results, including appropriate marketing, pricing and cost recovery analyses of the various products and services to be marketed by UHMG
- Is AFFORD on target with its planned phases for UHMG independence? Specifically, by the end of Year 3, the Growth Phase needs to be well developed with networks, partnerships, and distribution systems in place,
- What steps have been put in place to increase the financial viability and sustainability of UHMG and to move from Phase II to Phase III (Independence)?

Management, coordination and staffing

- Has the project staffing structure been appropriate to support program development and scale-up?

- How are partnerships developed and maintained with USG, GoU, civil society and other implementing partners?

- How will UHMG's management and staffing structure ensure it can handle the complex relationships that a broad program like AFFORD necessarily establishes?

ACTIVITY FIVE

5. End of Project Evaluation of Hospice Uganda

1. BACKGROUND

The recent Uganda Demographic and Health Survey (2006) estimated that about 1.1 million individuals are living with HIV in Uganda. All of them need palliative care (PC) whether on ART or not. Access to palliative care services has improved over the past decade, especially with increased resources coming through PEPFAR, Global Fund, World Bank and other bilateral programs. As at September 2007, 327,000 individuals were accessing palliative care services through USG PEPFAR supported programs. Currently, there are 124 PEPFAR supported sites in Uganda providing palliative care. In Uganda, palliative care is broadly defined to include all activities that enhance the quality of life of HIV infected persons, from diagnosis through end of life, and including post-bereavement care for family members. Available services include prevention and treatment of opportunistic infections (OIs), psychosocial support, home based care, nutrition, basic preventive care, TB Management, pain and symptom control, spiritual care and culturally appropriate terminal care. Few organizations can offer the full range of services, so coordination and establishment of referral networks to co-manage clients are essential elements of palliative care strategies. Generally, services are most comprehensive and accessible in urban areas, while few rural facilities are able to provide the full range of services.

USAID has supported palliative care services in Uganda since the early 1990's, initially through partnership with TASO. Building upon this partnership, and with increased resources through the PEPFAR initiative, the USG currently supports the largest palliative care portfolio in Uganda. As palliative care services evolve in Uganda, it is recognized that pain and symptoms, as well as terminal and bereavement care are essential needs within the overall continuum of care for PLHA but are not being addressed. In September 2005, USAID/Uganda entered into a three year Cooperative Agreement with Hospice Africa Uganda (HAU) to support expansion and integration of pain and symptom management as well as terminal care into existing HIV/AIDS care services. The overall goal of this $3 million program is to expand access and scope of palliative care services to people living with HIV/AIDS (PLHA) and their immediate families.

Hospice Africa Uganda is an indigenous NGO founded in 1994 to provide terminal care for cancer patients. HAU has since grown to become an accredited leader and one of the few institutions in Uganda and Sub Sahara Africa with technical expertise to provide and build capacity for pain and symptom management and end of life care. Realizing that most cancer patients were co-infected with HIV and also that cancer, mainly Karposis Sarcoma was one of the leading devastating symptoms among PLHA, HAU expanded its services to include HIV/AIDS care. Individuals with HIV/AIDS or HIV/Cancer are assessed and admitted into the program if they require specialist palliative care for pain and symptom management or end of life care. The care provided is a mix of home visits, out-patient care, outreach and hospital consultations. In an effort to ensure comprehensive care, HAU has strengthened linkages with other AIDS care and support organizations, to provide shared and complementary care and avoid duplication of services. For instance HAU refers PHAs

to HIV support organizations for social support interventions such as income generating activities while the same providers also refer to HAU the PHA that need pain and symptom control. Currently 2/3rd's of HAU HIV patients receive shared care.

Hospice directly manages services in three districts of Kampala (Head Office), Mbarara and Hoima. The directly managed programs have outreaches in neighboring districts. With USAID support, Hospice is expanding comprehensive palliative care service to five new districts of Mukono, Gulu, Rakai, Arua and Bushenyi district through a comprehensive training programme. Under this comprehensive program, HAU trains a body of palliative care providers right from the district hospital up to HC III. These include health workers as well as other non-health professionals such as teachers, social workers and religious leaders.

2. PURPOSE OF THE EVALUATION

The overall objective of this final project evaluation is to gain an independent opinion, regarding lessons learned and best practices developed during the implementation of the HAU HIV/AIDS palliative care program that would benefit the USG/Uganda and GOU partner institutions with future programming of palliative care services. The Mission also seeks recommendations that will inform the design and effective management of future palliative care activities. The evaluation will further assist HAU to know what worked and what did not work during implementation of the project, and ultimately inform its future strategies approaches for improving palliative care service delivery.

3. KEY EVALUATION QUESTIONS

1. To what extent has HAU succeeded in increasing access to and utilization of quality palliative care services, specifically diagnosis and management of pain, symptom control as well as spiritual and end of life care by people living with HIV/AIDS and their families?

    - What approaches did HAU use to improve accessibility to palliative care services for people living with HIV/AIDS and their families?
    - How successful has been the Comprehensive District Programme in scaling up access to quality palliative care services by people living with HIV/AIDS and/or cancer and their families?
    - How effective is the use of Community Volunteer Workers (CVWs) in delivery of palliative care services at community level?
    - How does the HAU model of palliative care compare with and/or complement other palliative care approaches in Uganda?

2. How has the HAU education program contributed to increasing availability of palliative care (pain management, symptom control and end of life care) to PHAs and their families?

    - Did HAU meet its stated targets under this objective?
    - How does HAU determine and respond to the demand for palliative care competence among other HIV/AIDS service organizations?
    - What have been the challenges in integrating pain management, symptom control and end of life care into existing HIV/AIDS care and support programs?

- What approaches is HAU using to institutionalise palliative care service delivery (pain management, symptom control and end of life care) within its client HIV/AIDS service organizations?

3. What approaches and strategies does HAU have in place to ensure future sustainability of its HIV/AIDS program?
   - What strategies has the project come up with in order to ensure that there's sustainability of its activities after project closure?
   - Did the project yield any unintended positive/negative results?

4. Is the program design appropriate to the achievement of the desired objectives?
   - Does the program design and structure adequately support and facilitate achievement of the desired results?
   - Is there early evidence suggesting whether program objectives will be reached and sustained?
   - Is the program on track to achieving its overall objectives and results as outlined in the results framework, work plan and reports?

4. DURATION:

The final evaluation report is expected not later than August 31, 2009.

5. COMPOSITION AND DURATION OF TEAM MEMBERS

It is essential that all team members understand the context of HIV/AIDS in Uganda. The team should number no more than five persons who, collectively, possess the skills and experience below:

- HIV/AIDS programming in Africa, with an added advantage of significant exposure to PEPFAR.
- Experience in delivery of palliative care services in peri-urban and rural settings.
- Organizational management and competences
- Capacity building for public health service delivery.
- Monitoring and evaluation.
- Financial management.

ACTIVITY SIX

6. Support for the Operationalization of the Uganda AIDS Commission's (UAC) Performance Monitoring and Management Plan (PMMP)

Brief Activity Description
The U.S. Government (USG) continues to support the Uganda AIDS Commission (UAC) in achieving the third one - one monitoring and evaluation system. With the near completion of a new five year national strategic plan, UAC, through a monitoring and evaluation subcommittee has also developed a national Performance Monitoring and Management Plan (PMMP) and an operational guide. The UAC is currently in the process of mapping out the technical support needs for the roll out of the PMMP. Areas of support will include database development and management, capacity building of UAC M&E staff and

operationalizing the PMMP through stakeholder meetings, curriculum development, training and reporting. This activity will not exceed $250,000 of year 1 funds. Once the areas of support are mapped out, USG will be able to identify which needs can be best met with PEFPAR support. These resources will be used to support the areas of need identified through a consultative process with UAC, donors and other stakeholders.

END OF SECTION C

SECTION D – PACKAGING AND MARKING

D.1 AIDAR 752.7009 MARKING (JAN 1993)

(a) It is USAID policy that USAID-financed commodities and shipping containers, and project construction sites and other project locations be suitably marked with the USAID emblem. Shipping containers are also to be marked with the last five digits of the USAID financing document number. As a general rule, marking is not required for raw materials shipped in bulk (such as coal, grain, etc.), or for semi finished products which are not packaged.

(b) Specific guidance on marking requirements should be obtained prior to procurement of commodities to be shipped, and as early as possible for project construction sites and other project locations. This guidance will be provided through the cognizant technical office indicated on the cover page of this contract, or by the Mission Director in the Cooperating Country to which commodities are being shipped, or in which the project site is located.

(c) Authority to waive marking requirements is vested with the Regional Assistant Administrators, and with Mission Directors.

(d) A copy of any specific marking instructions or waivers from marking requirements is to be sent to the Contracting Officer; the original should be retained by the Contractor.

D.2 BRANDING

The Contractor shall comply with the requirements of the USAID "Graphic Standards Manual" available at www.usaid.gov/branding, or any successor branding policy.

END OF SECTION D
SECTION E - INSPECTION AND ACCEPTANCE

E.1 TASK ORDER PERFORMANCE EVALUATION

Task order performance evaluation shall be performed in accordance with Project Search,

END OF SECTION E

SECTION F – DELIVERIES OR PERFORMANCE

F.1 PERIOD OF PERFORMANCE

The estimated period of performance for this task order is one (1) year

F.2. DELIVERABLES/RESULTS

See Section C.5 "**Deliverables**" for full information and definitive listing. All of the deliverables shall be submitted in the Final Report for each individual activity. The method and recipient of this information are outlined therein.

F.3 TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS

Contracting Officer
USAID/Uganda
Telephone: 256-41-306001
Fax: 256-41-306661

Cognizant Technical Officer (CTO) will be designated separately after task order award.

F.4 PLACE OF PERFORMANCE

The place of performance under this Task Order is Uganda, as specified in the Statement of Work.

F.5 AUTHORIZED WORK DAY / WEEK

No overtime or premium pay is authorized under this Task Order.

A six-day workweek for short-term assignments is authorized.

F.6 REPORTS AND DELIVERABLES OR OUTPUTS

In addition to the requirements set forth for submission of reports in Section I and in accordance with AIDAR clause 752.242-70, Periodic Progress Reports, the Contractor shall submit reports, deliverables or outputs as specified in the SOW for each activity. All reports and other deliverables shall be in the English language, unless otherwise specified by the CTO.

END OF SECTION F

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1 CONTRACTING OFFICER'S AUTHORITY

The Contracting Officer is the only person authorized to make or approve any changes in the requirements of this task order and notwithstanding any provisions contained elsewhere in this task order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other then the Contracting Officer, the change shall be considered to have been made without authority and no adjustment shall be made in the contract terms and conditions, including price.

G.2 TECHNICAL DIRECTION

USAID/Uganda's Investing in People team, HIV/AIDS sub-team, shall provide technical oversight to the Contractor through the designated CTO. The contracting officer shall issue a letter appointing the CTO for the task order and provide a copy of the designation letter to the contractor.

G.3 ACCEPTANCE AND APPROVAL

In order to receive payment, all deliverables must be accepted and approved by the CTO.

G.4 INVOICES

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to the USAID/Uganda Financial Management Office (FMO). One copy of the voucher and the invoice shall also be submitted to the Contracting Officer and the CTO.

Electronic submission of invoices is encouraged. Submit invoices to Ms. Juliet Kamanya at jkamanya@usaid.gov.

The SF-1034 must be signed, and it must be submitted along with the invoice and any other documentation in Adobe.

Paper Invoices shall be sent to the following address:

USAID/Uganda Financial Management Office
US Mission Compound, South Wing
2190 Kampala Place
Washington, DC 20521-2190

If submitting invoices electronically, do not send a paper copy.

END OF SECTION GSECTION H – SPECIAL TASK ORDER REQUIREMENTS

H.1 KEY PERSONNEL

The contractor shall provide the following key personnel for the performance of this task order:

(TBD)

USAID reserves the right to adjust the level of key personnel during the performance of this task order.

H.2 LANGUAGE REQUIREMENTS

All deliverables shall be produced in English.

H.3 GOVERNMENT FURNISHED FACILITIES OR PROPERTY

The Contractor and any employee or consultant of the Contractor is prohibited from using U.S. Government facilities (such as office space or equipment) or U.S. Government clerical or technical personnel in the performance of the services specified in the Task Order unless the use of Government facilities or personnel is specifically authorized in the Task Order or is authorized in advance, in writing, by the CTO.

H.4 CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY

All reports generated and data collected during this project shall be considered the property of USAID and shall not be reproduced, disseminated or discussed in open forum, other than for the purposes of completing the tasks described in this document, without the express written approval of a duly-authorized representative of USAID. All findings, conclusions and recommendations shall be considered confidential and proprietary.

H.5 CONTRACTOR'S STAFF SUPPORT, AND ADMINISTRATIVE AND LOGISTICS ARRANGEMENTS

The Contractor shall be responsible for all administrative support and logistics required to fulfill the requirements of this task order. These shall include all travel arrangements, appointment scheduling, secretarial services, report preparations services, printing, and duplicating.

H.6 PERIODIC PROGRESS REPORTS (July 1998) (CIB 98-21)

(a) The contractor shall prepare and submit progress reports as specified in the Schedule of this contract. These reports are separate from the interim and final performance evaluation reports prepared by USAID in accordance with (48 CFR) FAR 42.15 and internal Agency procedures, but they may be used by USAID personnel or their authorized representatives when evaluating the contractor's performance.

(b) During any delay in furnishing a progress report required under this contract, the contracting officer may withhold from payment an amount not to exceed US$25,000 (or local currency equivalent) or 5 percent of the amount of this contract, whichever is less, until such time as the contracting officer determines that the delay no longer has a detrimental effect on the Government's ability to monitor the contractor's progress.

END OF SECTION H

SECTION I – CONTRACT CLAUSES

I.1 Reference Project Search.

END OF SECTION I

SECTION J – LIST OF DOCUMENTS EXHIBITS AND OTHER ATTACHEMENTS

SECTION J - LIST OF ATTACHMENTS

J.1 USAID FORM 1420-17 Contractor Biographical Data Sheet

* A hard copy is attached at the end of this document; however, for an electronic version, please locate the form at http://www.USAID.GOV/procurement_bus_opp/procurement/forms/ .
The copy of the form is being provided herewith for reference purpose only.

END OF SECTION J

SECTION L - INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS

L.1 GENERAL

The Government anticipates the award of one (1) CPFF task order as a result of this RFTOP; however, it reserves the right to make multiple awards or no award.

L.2 ACQUISITION SCHEDULE

The schedule for this acquisition is anticipated to be as follows:

	Date
RFTOP issued	May 30, 2008
Questions due	June 16, 2008
Answers to questions disseminated	June 19, 2008
Proposals due	June 30, 2008
Technical evaluation	July 3, 2008
Award of task order	September 2, 2008

All Questions relating to this RFTOP must be submitted to Sam Nagwere at snagwere@usaid.gov via email no later than June 16, 2008. Unless otherwise notified by an amendment to the RFTOP, no questions will be accepted after this date. Offerors must not submit questions to any other USAID staff, including the technical office for either the Task Order or the basic IQC.

L.3 PROPOSAL INSTRUCTIONS

a) The offeror should submit the proposal electronically - internet email with up to 3 attachments (2MB limit) per email compatible with MS WORD and Excel in a MS Windows environment. Only those pages requiring original manual signatures should be sent via facsimile (Facsimile of the entire proposal is not authorized); or scanned and emailed as an attachment.

b) The Technical Proposal and Cost Proposal must be kept separate from each other. Technical Proposals must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit.

L.4 GENERAL INSTRUCTIONS TO OFFERORS

(a) RFTOP Instructions: If an Offeror does not follow the instructions set forth herein, the Offeror's proposal may be eliminated from further consideration or the proposal may be down-graded and not receive full or partial credit under the applicable evaluation criteria.

(a) Accurate and Complete Information: Offerors must set forth full, accurate and complete information as required by this RFTOP. The penalty for making false statements to the Government is prescribed in 18 U.S.C. 1001.

(b) Offer Acceptability: The Government may determine an offer to be unacceptable if the offer does not comply with all of the terms and conditions of the RFTOP.

(c) Proposal Preparation Costs: The U.S. Government will not pay for any proposal preparation costs.

L.5 INSTRUCTIONS FOR THE PREPARATION OF THE TECHNICAL PROPOSAL

(a) The Technical Proposal (TP) in response to this RFTOP should address how the offeror intends to carry out the Statement of Work contained in Section C. It should also demonstrate a clear understanding of the work to be undertaken and the responsibilities of all parties involved. The technical proposal should be organized by the technical evaluation criteria listed in Section M.

(b) Proposals are limited to **20** pages for all information requested herein, OVER 25 PAGES WILL NOT BE EVALUATED, and shall be written in English and typed on standard 8 1/2" x 11" paper or A4 (216mm by 297mm paper), single spaced, using Times New Roman font, regular, size 12 with each page numbered consecutively.

(c) The technical proposal shall include the following information:

1. Technical approach

The technical proposal should present strategic and technical approach (es) that describe how the offeror will effectively and efficiently achieve results outlined in the SOW, come up with a comprehensive performance monitoring plan to effectively monitor and report on the activities and results, and show clear understanding of the opportunities and constraints related to supporting the objectives and activities outlined in the SOW and achieving the planned results.

2. Personnel and Management Plan

The technical proposal should specify the composition and organization structure that will be effective and cost-efficient showing the entire implementation team and describe each individual's role, experience, technical expertise, and estimated amount of time each will devote to the project. Identify a maximum of three (those whose participation in the proposed activities is considered essential) by name and position, and quantified according to the level of effort planned under each activity area. Demonstrate commitment to using Ugandan and regional professionals and managers in carrying out the work. Include a biosketch (brief summary of each person's relevant work experience) for all technical personnel to be assigned to this program activity.

All required information on personnel is subject to the 25 page limitation.

3. Corporate Experience

Technical proposal should describe previous work performed by the offeror that is directly related or similar in scope, magnitude and complexity to that which is detailed in the RFTOP, i.e., Formative assessment , review and evaluation, end of project evaluations, and performance monitoring and management implemented in Africa, including local organizational strengthening/development. The information must be clear whether the work

by the Offeror was done as a prime contractor or a subcontractor. Experience in implementation of similar programs in Ugandan or E. Africa will be of added advantage. Please provide contact information for verification.

Offerors must either provide the above information or affirmatively state that they posses no relevant directly related or similar experience.

The corporate experience information and references required by this section shall be included within the 20 page limit.

L.6 COST PROPOSALS

a) In order to undertake a meaningful comparison of cost factors in this CPFF RFTOP, offerors are required to use the following template of standard cost elements:

COST-PLUS-FIXED-FEE BUDGET

Total Direct Labor	
Salary and Wages	$_____
Fringe Benefits	$_____
Consultants	$_____
Travel, Transportation, and Per Diem	$_____
Equipment and Supplies	$_____
Subcontracts (see note below)	$_____
Allowances	$_____
Participant Training	$_____
Other Direct Cost	$_____
Overhead	$_____
G&A	$_____
Material Overhead	$_____
Total Estimated Cost	$_____
Fixed Fee	$_____
Total Est. Cost Plus Fixed Fee	$_____

Total Cost-Plus-Fixed-Fee $

Note: Individual subcontractors should include the same cost element breakdowns in their budgets as applicable.

b) There is no page limitation for cost proposal. The above cost elements shall be supported by a detailed budget with detailed budget notes sufficient to permit an adequate cost realism analysis. Proposed salaries must be supported by EBDs (Attachment J.1).

c) The government estimate for this one-year program is in the range of $$1m to $1.5M.. Revealing this information does not mean that the Offerors should strive to meet the maximum amount. Offerors must propose costs that they believe are realistic and reasonable for the work. Cost proposals will be evaluated as part of a best value determination for task order award, including cost effectiveness approaches to achieving the results.

END OF SECTION L

SECTION M – EVALUATION FACTORS FOR AWARD

M.1 GENERAL INFORMATION

(a) The Government may award a task order without discussions with offerors.

(b) The Government intends to evaluate task order proposals in accordance with Section M of this RFTOP and award to the responsible contractor(s) whose task order proposal(s) represents the best value to the U.S. Government. "Best value" is defined as the offer that results in the most advantageous solution for the Government, in consideration of technical, cost, and other factors.

(c) The submitted technical information will be scored by a technical evaluation committee using the technical criteria shown below. The evaluation committee may include industry experts who are not employees of the Federal Government. When evaluating the competing Offerors, the Government will consider the written qualifications and capability information provided by the Offerors, and any other information obtained by the Government through its own research.

M.2 TECHNICAL PROPOSAL EVALUATION CRITERIA

The specific evaluation criteria are as follows:

A. Technical Evaluation Criteria

A.1. Technical Understanding and Approaches (50 points)

The offeror reflects excellent understanding of USAID, the overall Scope of Work and its objective, and the ability to synthesize and apply the lessons learned from similar activities. The offeror clearly demonstrates:

- Understanding of the opportunities and constraints related to supporting the objectives and activities outlined in the SOW and achieving the planned results.
- Sound strategic and technical approach(es) that describe how the offeror will effectively and efficiently achieve the results outlined in the SOW.
- A comprehensive performance monitoring plan to effectively monitor and report on activities and results.

A.2. Personnel & Management Structure (30 points)

Proposal demonstrates key personnel have requisite breadth and depth of technical expertise and experience in management, planning and provision of specialized technical assistance necessary for achievement of program results. The proposal clearly:

- Demonstrates effective and cost-efficient management structure to achieve project goals, objectives and targets.

- Proposes personnel who have relevant professional qualifications and experience appropriate to manage and achieve results.

- Demonstrates commitment to using Ugandan and regional professionals and managers in carrying out this activity.

A.3. Institutional Capacity and Past Performance (20 points)

Offerors will be evaluated on the basis of the extent to which they can:

- Demonstrate organizational knowledge and institutional capability to develop, manage, implement, monitor and evaluate similar activities in Africa.

- Ability to facilitate rapid implementation.

- Describe relevant work experience and representative accomplishments in managing and implementing similar programs.

USAID reserves the right to obtain past performance information from other sources including those not named in the offeror's application.

Technical versus Cost considerations: For this RFTOP, technical considerations are more important than cost.

B. Cost

Not a weighted factor. The cost applications of technically acceptable applicant(s) will be evaluated for necessity, reasonableness, allowability, and allocability of cost elements included in the budget. Cost-effectiveness and cost-realism are the other factors in determining appropriateness of the application.

END OF SECTION M

ATTACHMENT J.1 USAID FORM 1420-17 - CONTRACTOR BIOGRAPHICAL DATA SHEET

CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET

1. Name (Last, First, Middle)	2. Contractor's Name	
3. Employee's Address (include ZIP code)	4. Contract Number	5. Position Under Contract
	6. Proposed Salary	7. Duration of Assignment

8. Telephone Number (include area code)	9. Place of Birth	10. Citizenship (if non-U.S. citizen, give visa status)

11. Names, Ages, and Relationship of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)

13. LANGUAGE PROFICIENCY (See Instructions on Reverse)

NAME AND LOCATION OF INSTITUTE	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading

14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.
2. Salary definition - basic pariodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (M/D/Y)		Annual Salary
		From	To	Dollars

15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (M/D/Y)		Days at Rate	Daily Rate in Dollars
		From	To		

16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee	Date

17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that the USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fradulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date